Medical Tribune and Medical News

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Vol. 15, No. 32 — *world news of medicine and its practice—fast, accurate, complete* — Wednesday, August 28, 1974

making rounds / at press time

FORD AND HEALTH - Does President Ford's emphasis on reducing federal spending mean a health budget cut? Health chief Dr. Charles C. Edwards told MT that "if we have to live with a far tighter budget, we'll live with a far tighter budget, and still get a helluva lot accomplished, I hope." On National Health Insurance, which Mr. Ford urged passed this year, Dr. Edwards was "hopeful, but not overly optimistic."

FORD'S M.D. - The President, say UPI, is expected to appoint as his personal physician Rear Adm. William Lukash, chief, gastroenterology clinic, National Naval Medical Center and one of Mr. Nixon's M.D.s.

DENENBERG DENIED - Herbert Denenberg, Ph.D., controversal former Penna. insurance commissioner and unsuccessful Senant aspirant, has been refused admission to the state bar, despite approval by board of law examiners.

MEDICAID MESS - The U.S. Senate Finance Committee and a Chicago grand jury are investigating laboratories charged with padding bills for unnecessary tests or tests never given, and kicking back to M.D.s. IRS is also investigating - one doctor's income reportedly went from $36,000 to $200,000. Dr. Frederic D. Lake, president of the Illinois Medical Society, says only a few M.D.s are involved and calls for their prosecution.

PEOPLE - Dr. Chandler A. Stetson, U. Florida College of Medicine dean, now its vice president for health affairs . . . Dr. Edmund D. Pellegrino, chancellor for health sciences at U. Tennessee, appointed board chairman of Yale-New Haven Medical Center . . .

Holland 1st Stop on World Tour of General Practice

With an intimate portrait of a Dutch general practitioner, Dr. Dirk Van Leeuwen above, MEDICAL TRIBUNE begins, on page 12, an exclusive series on how physicians practice around the world. Dr. Van Leeuwen's family spends Sundays cycling along Holland's dikes.

Cereal Nutrient Plan Revives Row Over Food Fortification

BY NATHAN HORWITZ
Medical Tribune Staff

WASHINGTON—The mandatory addition of 10 nutrients to cereal products—recommended recently by the National Research Council's food board—has renewed the dispute over the issue of food fortification. But sources believe it will not generate the kind of conflict sparked by the proposal to increase the amount of iron in bread.

"We are anticipating a lot of comments, but we don't expect anything like the controversy over iron," said Dr. Joginder Chopra, acting director of the Food and Drug Administration's Division of Nutrition. She noted, however, that the FDA has already extended to October 1 the discussion period allowed after official publication of the recommendations, as modified by the FDA. The proposals were published in the *Federal Register* in late June.

"The NRC has put forward broad guidelines to help correct deficiencies in the American diet, and we have adopted those guidelines, on the whole," she declared. "We are now in the process of examining the proposals product by product."

The recommendations, put forward

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Breast Ca Parley Backs Estrogen Receptor Assay

Medical Tribune Report

BETHESDA, MD.—It's not ready for widespread use yet, but the estrogen receptor assay continues to show promise as a valuable tool in the management of breast cancer patients.

This was the consensus after a two-day workshop sponsored by the Breast Cancer Task Force of the National Cancer Institute, at which investigators from 11 countries discussed various techniques for measuring the estrogen-binding capacity of tumor cells and the value of such measurements in predicting the response to various forms of endocrine therapy.

Their findings generally confirmed earlier reports that where estrogen receptor is present in tumor cells there is a good chance that the patient will respond to some form of endocrine therapy: either ablative (oophorectomy, hypophysectomy, or adrenalectomy) or additive (estrogens, androgens, or anti-estrogens). Where no estrogen receptor is present, the patient will not respond to hormonal therapy.

A major finding, according to workshop cochairman Dr. Paul Carbone, associate scientific director of medical oncology in NCI's Division of Cancer Treatment, was that evaluation of the estrogen-binding capacity of the primary lesion "may help us decide on the treatment of the breast cancer patient when she becomes metastatic."

Dr. William L. McGuire, Department of Medicine, University of Texas Medical School, who also served as conference cochairman, again reported (see MEDICAL TRIBUNE, June 12)

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Blacks Still Face Hate, Bias in Health Field—Dr. Rann

Medical Tribune Report

NEW ORLEANS—In health circles, retiring president of the National Medical Association said, "there is still race hate, racial prejudice and discrimination."

As he spoke the words, Dr. Emery L. Rann of Charlotte, N.C., stood on a rostrum in a hotel which occupies the site where, on July 30, 1866, at least 38 blacks were killed and 146 wounded in a post-Civil War clash with whites.

DR. RANN

In 1974, black delegates and their families attending the N.M.A.'s 79th annual convention were given red carpet treatment, welcomed in hotels, restaurants and public transportation vehicles, and by most taxicab drivers, who found them to be liberal tippers.

Dr. Rann himself remarked on the difference since the late 1950s and the 1960s when the N.M.A. "began meeting in convention hotels instead of in the local high schools, with members residing in private homes."

Yet he bemoaned the fact that "from within medical circles we . . . face problems. There is still race hate, racial prejudice and discrimination.

"There is still poverty. There is still a 'don't care' attitude on the part of many affluent doctors. In many clinics in America, in many hospitals, the patient, if he cannot pay the costs, is not admitted for care no matter how emergent the case might be."

Minority medical students, he complained, "are being admitted into training because of government money and, because they are of minority groups, are often pressured out of school.

"One young woman in a Midwestern medical school, a Phi Beta Kappa who led her class in getting her MS degree, entered medical school and was doing satisfactory work until someone noticed that her last name was the same as that of a noted Black Panther on the West Coast. So they began working on her. Daily she was called in for conferences on her political belief, her social concepts, until her grades began dropping off and the young lady dropped out of school in sheer desperation.

"In another Big Ten university, a professor publicly proclaimed that no 'nigger' would ever pass his course. And at present, in a Midwestern medical school, the professor of pathology is trying to flunk out several brilliant black students and admitted in a fac-

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Unwed Teen-Agers Bearing and Rearing More Children

By MARGERY BARNETT
Medical Tribune Staff

BALTIMORE—The teen-age sexual revolution, whatever it may be in adult minds, is not simply a wild upsurge in premarital sexual activity; it is also an increase in illegitimate child-bearing and rearing among women under 20.

Thirty per cent of girls aged 15-19 have had premarital intercourse; thirty per cent of those who have premarital intercourse also have a premarital first pregnancy. Many abort or marry before delivery, but a surprising number raise their babies out of wedlock.

With effective contraception universally available and legal abortion mandated by the 1973 Supreme Court ruling, why do teen-agers conceive and raise children outside of marriage? In 1970, the last year for which national natality statistics are available, teen-agers contributed 17 per cent of all live births and almost half of all illegitimate births in the United States.

1971 Survey Cited

In 1971, Professors Melvin Zelnik, Ph.D., and John F. Kantner, Ph.D., of the Department of Population Dynamics at the School of Hygiene and Public Health, Johns Hopkins University, conducted a national-sample survey of the premarital sexual behavior and pregnancy outcome of girls aged 15-19.

For the three in ten of the sexually active teen-agers whose activity led to a first premarital pregnancy, they found that 60 per cent married before delivery, with 30 per cent delivering out of wedlock. Among sexually active non-whites, 84 per cent conceived before marriage, 39 per cent married before delivery. Among whites, 50 per cent conceived before marriage, 83 per cent married before delivery, they report in *Family Planning Perspectives*, a publication of Planned Parenthood Federation of America, Inc.

Of those who did not marry, 85 per cent of the blacks and fewer than 50 per cent of the whites had live births; forty per cent of the whites and 5.8 per cent of the blacks had induced abortions.

Illegitimacy 'Probably Down'

Although they do not have comparable hard data since their 1971 survey, "I think the illegitimacy trends are probably down," Dr. Kantner told MEDICAL TRIBUNE. "Liberalization of abortion and contraceptive services would tend to reduce 1971's high rates."

"But a profound change in teen-age sexual behavior in recent years underlies the figures; there is a sharply increased probability of intercourse at each age level. We found that the probability of a girl currently aged 15 having intercourse is three to four times greater than the probability that a girl now aged 19 had intercourse when she was 15."

Teen-agers are not homogenous, however; their experiences differ in different places and groups. Where legal abortion is virtually unavailable, teen-age illegitimacy rates rise. In a state such as New York, the rate dropped 16 per cent in the year after legal abortion became widely available—after many years of skyrocketing annual increases.

Similarly, California's teen-age illegitimacy rate dropped 15 per cent immediately after the state liberalized its abortion laws in 1971. But demographer June Sklar, Ph.D., at the University of California at Berkeley, and statistician Beth Berkov of the State Department of Health, found that the decline quickly leveled off. The illegitimacy rate rose three per cent in 1972, and another three per cent in 1973 among white teen-agers, though it continued to decline among non-white teenagers.

They also found that many more white teen-aged girls were keeping their illegitimate babies; by 1971-2, only 15 per cent of these babies were given up by their adolescent mothers.

They offer several possible reasons why these young women didn't use contraceptives they knew about, abortion services accessible to them, or adoption services. In their sample, teen-agers often expressed negative views toward contraception, saying that contraceptives were not consistent with the teenage belief in sex as natural and spontaneous and that they might be harmful to health. Many thought most of the cycle was "safe" or that they were too young to get pregnant.

Most surprisingly, many of them wanted to get pregnant or at least didn't mind—a finding that also turned up in the 1971 Hopkins sample, in which a fourth of the black and a third of the white teen-agers reported that they had wanted their first, premarital pregnancies.

Why? Dr. Sklar and Ms. Berkov speculate that pregnancy may have seemed the shortest road to marriage: 50 per cent of the white and eight per cent of the black teen-agers were married before their babies were born. **But they note in *Perspectives* that** "the recent decline in the teen-age marriage rate suggests that for many young girls, the gamble of forcing marriage with a premarital pregnancy has not paid off."

Why, the investigators ask, have the baby rather than legally abort? The answer may be partly due to recent shifts in social attitudes: respect for motherhood remain strong, prejudices for illegitimacy have weakened.

But strong negative feelings and experiences with abortion may play a large role, Dr. Kantner said. "We found that a large proportion of black girls had negative attitudes toward abortion; they thought of it as always very dangerous, immoral—a form of murder—and they had often had unsuccessful or bad experiences when they tried to end the pregnancy with abortion."

Contrast in Abortion Success

Among those who were pregnant but not married and who had sought abortion, Dr. Kantner said, most of the white girls had successful abortions under medical auspices; over 40 per cent of the black girls were unsuccessful, most of their abortions conducted in private homes, under inadequate medical supervision.

Leo Morris, Ph.D., Assistant Chief of the Technical Assistance Section, Family Planning Evaluation Division at the Center for Disease Control in Atlanta, observed that obstacles placed in the path of teen-agers seeking contraception overwhelm other reasons for their increasing illegitimacy rates. In the Hopkins survey, he points out in *Perspectives*, though three out of four girls did not wish to conceive, only half used contraception, often such ineffective methods as douche or withdrawal.

He estimates that only 20 per cent of sexually active teen-agers use effective contraception, 5 per cent obtained through private physicians, 15 per cent through public services. The other 80 per cent, an estimated 1.1 million young women, receive no medically supervised contraceptive service.

"Granted the existence of need, can services be provided to teen-agers in such a way that the services will be used? Teen-agers appear willing to use facilities responsive to their needs and teen clinics are especially adapted to the needs and sensitivities of teen-age patients."

Adequate services, he stresses, must be based on the realities of teen-age sex norms. "When contraception is regarded as inappropriate for unmarried persons, many unmarried minors will gain access to medical family planning services only after having an out-of-wedlock pregnancy."

That pregnancy is likely to end in teen-age childrearing, the Hopkins survey found: nine out of ten black children, seven out of ten white were living with their unmarried teen-age mothers.

Glucose Test for Diabetes Held Obsolete if Used Alone

Medical Tribune Report

CHICAGO—The glucose tolerance test was described here as an "obsolete procedure" unless it is used in conjunction with an insulin radioimmunoassay in diabetes detection studies.

Reporting the findings in a study of more than 2,500 correlated glucose/insulin tolerance tests, Dr. Joseph R. Kraft, of the University of Illinois School of Medicine, said that "many patients who would be considered nondiabetic on the basis of glucose tolerance testing alone were actually shown via an associated insulin assay to be occult diabetics."

In describing his work at an A.M.A. symposium on the Radioimmunoassay in Diagnostic Medicine, Dr. Kraft, who is Associate Clinical Professor of Pathology, explained that he was defining prediabetes as a state "in which glucose tolerance values are normal, but an insulin assay pattern is consistent with diabetes mellitus." In this definition, prediabetes and occult diabetes become synonymous.

The subjects used in the glucose/insulin studies included 956 males and 1,601 females, with a mean age of 50. Twenty-three per cent of the males and 37 per cent of the females were obese but a "significant causal relationship between obesity and diabetes mellitus could not be demonstrated," he said.

The data revealed five insulin patterns, one of which was established as normal, the investigator noted. "Normally insulin will peak within the first hour following a glucose load and this typical pattern was found in 917 cases . . . Maximum insulin peaks occurred at ½ hour in 36 per cent and at one hour in 64 per cent. Thereafter, insulin levels declined sequentially at two and three hours, returning to fasting range." A normal insulin fasting level, Dr. Kraft said, ranged between 0 and 30 microUnits.

Four Other Patterns

Because the second and third hour insulin response is critical to the diagnosis of diabetes, he continued, this period was further defined in relation to the normal pattern. Analysis of the findings disclosed these four other patterns:

- A normal peak at ½ or one hour, but a delayed return in 763 cases or 30 per cent of the series, a pattern "diagnostic of diabetes mellitus."
- Insulin peaks appearing later than one hour, observed in 815 cases; or delayed until the third hour, observed in 192 cases. Both of these levels are viewed as diagnostic of diabetes.
- Fasting insulin levels greater than 50 microUnits, detected in 184 cases. "Forty per cent of the patients exhibiting the high fasting pattern were obese, compared with a 32 per cent incidence for the total series, thus negating a significant relationship between obesity and high fasting insulin levels."
- The fifth pattern, observed in 100 cases, showed a low insulin fasting response of 0 to 30 microUnits and was associated with tolerances which were either normal or borderline, consistent with an insulinopenic or "juvenile" response pattern indicative of significantly reduced insulin production. "In the absence of pancreatic gland dysfunction," Dr. Kraft stressed, "such an insulin pattern suggested low carbohydrate diet preparation and/or management. In these cases, standard high carbohydrate diet preparation followed by repeat tolerance examination was necessary to uncover the true insulin response pattern. It was not possible, purely on the basis of the initial tolerance to predict whether the subsequent insulin response would be normal, borderline or delayed."

Dr. Kraft commented that the demonstration that low carbohydrate diet could affect insulin response has been useful in evaluating and monitoring such diets as part of the diabetic management programs.

Melbourne Area Women Antirubella Drive Target

Medical Tribune World Service

MELBOURNE, AUSTRALIA—The Royal Australian College of General Practitioners is launching a campaign to have every woman of childbearing age immunized against rubella. It is hoped that 200,000 vaccinations will be given

Europeans Divided on E. Coli Manipulation

Medical Tribune World Service

GENEVA—Investigators in Europe are reacting with concern to an appeal by a group of prominent U.S. biologists to halt certain types of genetic experiments.

The council of the 290-member European Molecular Biologists Organization (EMBO) is already planning a meeting to consider whether the appeal, published in *Science* and *Nature*, should be followed, Prof. Niels Jerne, EMBO president, told MEDICAL TRIBUNE in a telephone interview.

European scientists are taking positions along a broad spectrum of views on the controversy, which relates to genetic manipulation of Escherichia coli.

Wide Range of Views

Views range from support for a clear-cut ban on the two specific types of experiments described in the appeal, to opposition to any restrictions.

The U.S. appeal was launched by a group that includes Dr. Paul Berg, of Stanford University School of Medicine; Dr. David Baltimore, of the Massachusetts Institute of Technology; and Dr. James Watson, the Nobelist who now directs the Cold Spring Harbor laboratory of quantitative biology on Long Island.

The U.S. scientists warned that work planned by several research teams, including signatories to the appeal, would create new types of infectious DNA elements whose biological properties cannot be predicted in advance.

They have asked scientists throughout the world to join them in voluntarily deferring experiments which would involve:

- Implanting various types of drug resistance in bacteria now lacking it.
- Attaching oncogenic or other viruses to the plasmids of bacteria, or to the DNA of other viruses.

Support for the idea of warning the scientific community of the possible risks was voiced by Professor Werner Arber, of Basle University, Switzerland.

Because the experiments are simple to do, Dr. Arber fears "headline seekers" may rush to be first to recombine a possibly oncogenic virus with a fragment of a bacterial strain in a race for fame. "This is only one very specific application which comes to mind because the money flows easily in cancer research," he commented.

Dr. Arber says it is urgent to define the guidelines for controls in this area of research. Control is not complicated, he points out. "There are laboratories using pathogenic material all over the world. The problem is that people working with the new protein enzymes that can cut up DNA are biochemists. They have no idea of the danger of a virus or of pathogenic bacteria and do not work in sterilized conditions. Such work should be done only in a microbiological laboratory where all protective measures are taken."

Responsible scientists acquainted with the field should get together and discuss precisely what action should be taken, in the view of Prof. John H. Suback-Sharp of the institute of virology at the University of Glasgow, Scotland. "A case has been made by serious scientists which persuades me it is reasonable for this problem to have the consideration of an expert committee," he told MEDICAL TRIBUNE.

The area of experimentation has wide significance and is likely to attract "all sorts of people." Given the money to take adequate precautions, the experiments could well be done, "but I'm not at all sure that anyone who wishes to do them would necessarily do them under safe conditions."

It is better to stop this experimentation right now, in the view of Dr. Georges Cohen, molecular biologist at the Pasteur Institute in Paris. As for the argument of advancing knowledge: "Things have been learned from producing atomic bombs, also. This is a matter that transcends science and not all experiments should be done. Scientists should have some ethics, too."

In agreement with Dr. Cohen, is Prof. Hans Zadhau of the Institute for Physiological Chemistry in Munich, West Germany. "We in Europe are just as aware as those in the U.S. of the risks involved. Personally, I have the feeling certain experiments should not be done, I am not doing them, and I would prefer that nobody else does them either."

Dr. Jerne's Position

EMBO President Dr. Jerne, who is director of the Basle institute for immunology, Switzerland, takes a more neutral position. It could have been considered dangerous to culture polio virus in large amounts, Dr. Jerne points out. "Still, it was done to make the vaccine."

The new techniques offer advantages for the study of mammalian genes, Dr. Jerne went on. One of the questions not so far off in his laboratory is the genetic basis for antibody formation in vertebrates. "If part of the genetic material during this antibody formation in vertebrates could be studied in bacteria, this would offer advantages and be entirely harmless. There are no safety problems involved here."

"There are inherent dangers in much of our work. We must get some knowledgeable people together to determine whether we should limit this technique or not—and that is what we intend to do in EMBO. Simply calling a halt to the research does not necessarily solve any problems at this point."

Dr. Peter Hofschneider of the Max-Planck Institute for Biochemistry in Munich, West Germany, agrees. "All research can be dangerous—so are knives," says Dr. Hofschneider. "If you can avoid escape from the laboratory of the E. coli with new plasmids, then it is not dangerous."

In the coming 10 to 20 years it may be possible to produce important biological materials for use in genetic therapy of inborn diseases. "Rather than stop the experiments, it is better to take the proper precautions in well-equipped laboratories," he says.

The potential for medical progress is far too great to call a halt to such research, according to Prof. Martin Billeter of the Institute of Molecular Biology at Zurich University, Switzerland. With proper controls, he feels, the danger involved is not going to be great. There is now the possibility of replicating all sorts of DNA as plasmids in E. coli, Dr. Billeter said.

Battery-Driven Walker

A walker that goes in all directions but reverse for youngsters with spina bifida has been developed by Dr. M.A. Townsend, of Toronto University's mechanical engineering department. Powered by rechargeable motorcycle batteries, it frees patients of crutches or wheelchairs.

'Gay' Activists In France Break Up Sexology Parley

Medical Tribune World Service

PARIS—The Homosexual Action Front recently broke up a sexology meeting here, charging that speakers were not giving adequate attention to the problems of homosexuals.

Full Airing Promised

Dr. Jacqueline Kahn-Nathan, chief of the gynecologic clinic at the Paris Faculty of Medicine, promised the group a full airing during an upcoming international congress on medical sexology, including the possibility that homosexual physicians will be among the speakers.

She asserted that France shows a "serious lag" in the field of medical sexology.

ECTOPIC BEAT

"Previous epidemiologic case-control investigations have demonstrated an increased risk of thromboembolism associated with the use of oral contraceptives. Laboratory, experimental and prospective studies (in men) confirm this association."
—Abstract in program of 1974 A.M.A. meeting.

And who cares about women, anyway.

(Regular beat: Immunia Medica, page 23.)

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CLINICAL NEWS NOTE: *"Accurate prognosis, i.e. judgment regarding the probability of recurrences or chronicity, at the time of the first attacks of asthma, is pratically impossible. Only after extended observations, appropriate allergy tests, and therapeutic trials can a diagnostic classification of asthma be made and the likelihood of persistent or intermittent symptoms be estimated." (Dr. Constantine J. Falliers, see pg. 16)*

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OUR REGRETS

Due to increased postage, paper, and printing costs, a year's subscription to Medical Tribune is being raised to $25.00, effective September 1. Student rate will remain $7.50

If there's good reason to prescribe for psychic tension...

When, for example, despite counseling, tension and anxiety continue to produce distressing somatic symptoms

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Current Opinion

Take It To Court

By CHARLES HARRIS, M.D., F.C.A.P.

In reference to Dr. Sackler's column (MEDICAL TRIBUNE, August 7), you make mention that the basic rights of the American people includes health, but that this issue is being "politicized".

The word "politicized" is not quite accurate, for once the Congress passes a law involving the medical (or any other) field, the issue is taken out of the political arena and placed in the administrative ball-park, fenced in like a ball game wherein the public can play no more active part than that of audience—except, of course, that their future is being played out before their eyes.

'No Politics of Reversal'

Once a political issue is turned into Congressional law it becomes untouchable. There is no politics of reversal. There is no single person any longer responsible for the situation—it is merely codified prescription against which no countervailing force can be mounted politically.

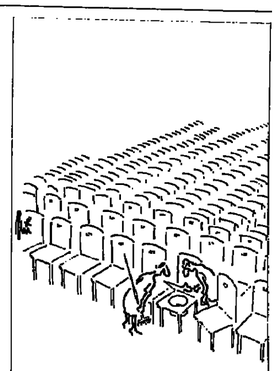
As a result, since we now find ourselves and our patients oppressed by insensitive laws that will surely destroy the public faith in the medical profession, the only recourse is to the courts. The judiciary is the balancing power that must be used to contain flagrant law. Doctors must avail themselves of this, otherwise surely our freedoms will be lost. A health-industrial complex will be a more direct path to the loss of freedom in this country than the military-industrial complex, because no elected official can cast a vote against "health".

Charles Reich, in the *Greening of America* made this point. He said that politics admits controversy, and permits an ebb and flow of the forces of opinion. In contradistinction, administration is harsh, violent in its methods, and as a result, fundamentally dictatorial. He fears that the extension of administrative law covering every aspect of life will deprive us eventually of our freedoms.

Recourse in Courts

Certainly we can see in the medical field, that the PSROs, the questionably constitutional certificates of need, the utilization committees, the usurpation of individual prerogatives, finally serve to do nothing but prevent reasonable men from doing their jobs in a reasonable way.

Actually, we must struggle to place these issues back into the political arena, and the only recourse towards this end, I fear, is to take the issues to court—continuously.



5 Scientists Urge U.S. to Promote Fiber-Rich Food

Medical Tribune Report

WASHINGTON—Five U.S. scientists, four of them physicians, are urging Federal action to increase the fiber consumption of the American diet.

The recommendation was contained in a "white paper" on dietary fiber and health authored by Dr. William O. Dobbins, director of the division of gastroenterology at George Washington University Medical Center, Dr. Franz Goldstein, chief of gastroenterology at Lankenau Hospital in Philadelphia, Dr. Daniel H. Connor, chief of the geographic pathology division of the Armed Forces Institute of Pathology, Dr. Stuart Danovitch, a D.C. gastroenterologist, and Michael Jacobson, Ph.D., codirector of the Center for Science in the Public Interest (CSPI), a Ralph Nader-inspired group.

Inadequate roughage in the American diet, they noted, has been suggested as perhaps being responsible for diverticular disease.

Urging physicians, nutritionists, and public health officials to promote consumption of fiber-rich foods, they also suggested several steps to be taken by Federal agencies. These include:

- FDA encouragement of the consumption of fiber-rich foods, through its authority to approve foods used in its school lunch and breakfast programs, and food stamp programs.
- Inclusion of more dishes made with whole grains, bran, legumes, fruits, and vegetables in the meals served to servicemen and civilian employees by the Department of Defense.
- NIH-sponsored research into the relationship of Western diet to Western disease.

HEW Finally Unkinks Medical Student Aid Program

BY KEN SANDLER
Special Tribune Correspondent

WASHINGTON — The Department of Health, Education, and Welfare has finally unkinked its medical student loan and scholarship program administration.

The straightening out came about the time that the General Accounting Office—Congress's investigatory agency—concluded that the aid programs' current intrinsic value is minimal.

Program Inadequacies Cited

The GAO investigation found that the Federal loan and scholarship program funds do little to increase enrollment—medical schools are already operating at capacity; that they have almost no influence on geographic redistribution of physicians—medical students don't consider the government subsidies sufficient inducement to locate where they don't want to; that funds often don't go to the neediest students—the definition of need varies from medical school to medical school; and that Federal funds awarded via college administrators are at times questionably managed—Baylor College of Medicine, for instance, awarded a $1,000 Federal loan to a student who needed the money to pay for his girl friend's abortion.

Major Federal subsidy programs include Federal loans administered by the schools, bank loan guarantees, and National Health Service Corps reimbursements.

Another is the Physician Shortage area scholarship and loan forgiveness program. The scholarships provide $5,000 per year for up to four years; for each year of assistance the student must serve a year in a stipulated physician shortage area.

The Defense Department will also pay for a medical student's education and living expenses if the student will sign up for a tour in the armed forces.

But the program that has drawn the most criticism recently is the National Health Service Corps loan-forgiveness program. A graduate serving one year in the corps has 30 percent of the costs of his medical education repaid by the government, two years service qualifies him for a 60 percent reimbursement, and three years service will buy an 85% reimbursement.

Foul-up on Loan Rebates

Because of a bureaucratic foul-up or misunderstanding, students who signed up for service under the impression that they would get loan rebates weren't provided with the appropriate loan forgiveness document to sign, and because the documents weren't signed when their service began, the students soon found that they were serving but the government wasn't paying. HEW officials said there could be no retroactivity to the rebates despite the service and good faith of the students. HEW also admitted that the misunderstanding and delay in getting the forms out was its own fault.

After Congressional reaction to the complaints by NHSC members intensified, HEW officials pressured HEW secretary Caspar Weinberger, who pressured the HEW legal people, who reversed themselves and told the former students there would be retroactivity after all. The amount of money involved—less than half a million dollars—was small, but the bad-faith image HEW had developed was far larger.

The GAO report on the basic merit of the various aid programs may have substantial impact on the future form of Federal aid to students.

Of the 86 non-NHSC physicians and 133 dentists who had obtained cancellation of portions of their Federal loans by practicing in designated shortage areas through last October, 167 responded to a GAO query on the significance of the loan-forgiveness program. More than 80% said that they would be practicing in the shortage areas even if there had been no loan-forgiveness program.

This response could, however, indicate that those students who are most hard pressed financially chose the NHSC or armed forces service for relief of their medical education obligations.

The GAO also found that of school-administered Federal loans, "criteria have not been provided to the schools to carry out the provisions of the [manpower] legislation for awarding loans to students with need, and scholarships to students with exceptional financial need. The schools in our review had adopted a variety of methods and criteria for awarding scholarships, and some had not consistently applied the criteria adopted.

"Decisions to award scholarships sometimes appeared arbitrary and were often inconsistent, both between schools and within schools, and did not necessarily benefit students with the greatest computed need or from the lowest income families."

No Relationship to Income

The GAO reported that "on the basis of our random sample of [aid] recipients, there was no significant relationship between family income reported by the students to the schools and the amount of scholarship [the] students received at 11 of the 13 schools we reviewed.

"At UCLA, for example, over one half of the 52 students in our sample received more aid than the school had determined they needed; seven of these students received about twice as much as they needed. An aid official stated that in almost all cases where a student received more aid than needed, it was because he received outside aid."

Some students at various schools, by sharp maneuvering, were able to get the Defense Department to pay them for their education and at the same time get other Federal financial aid.

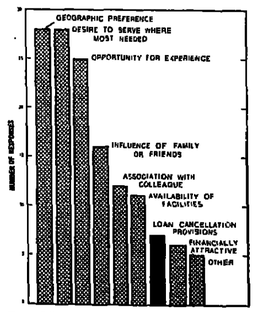
The GAO said that "most of the students indicated that they would be willing to participate in an all-loan program . . . and "because of the anticipated repayment capability of doctors . . . there may not be a need to subsidize their education through scholarships."

Federal aid, the GAO concluded, "is being given to students who would probably attend medical school even if such aid was not available. To this extent, it does not appear to be effective in attracting students from disadvantaged family backgrounds who could not otherwise afford to attend medical school. . . ."

One year ago, an HEW memorandum related that graduating physicians and dentists were coming out of school with about $7,000 in debt each. The memo also stated that if the debt level were increased to some $20,000 to $30,000 per student, debt forgiveness could then be a genuine incentive for students to practice in shortage areas.

HEW, in its 1975 budget request, asked for a $19,000,000 increase in funds for NHSC incentive programs. And while it is almost certain that funds substantially in excess of the $3,000,000 appropriated for the NHSC aid program for fiscal 1974 will be authorized for fiscal 1975, there is still no 1975 budget—despite the fact that fiscal 1975 has already begun.

Location Reasons



Few M.D.s gave loan forgiveness as reason for moving to shortage area.

. . . brief summaries of editorials or comments in current medical and scientific journals.

Genetic Research Embargo

The recommendations of leading United States molecular biologists, acting through the National Academy of Sciences, that certain experiments involving genetic manipulation of bacteria be stopped as a matter of self-regulation by scientists until their health hazards can be assessed "seems certain to raise a debate about the social implications of genetic engineering. . . ." Yet "this is not the focus of the National Academy of Science group's concern. Their worries are confined specifically to the possible health hazard of genetically altered bacteria.

"The embargo presents a significant test of the scientific community's ability to regulate itself in a responsible way. As group member David Baltimore of MIT observed . . . failure to observe the recommendations could lead to even harsher restrictions being imposed by law. The real test of the scientific community's cohesiveness will come when and if the international conference to be convened in February decides that the embargo should be extended indefinitely. So far, Paul Berg's committee has set what should be a notable precedent in the responsible control by scientists of socially threatening advances in genetic engineering." *(Comment. Nicholas Wade. New Scientist 63: 170, July 25, 1974)* [See editorial, page 11.—Ed.]

The Obliging Wart

"There is no place for enthusiasm in the treatment of warts. Burning, freezing, curettage, and the chemical attack are all uncomfortable: the child screams, the dermatologist sweats, and the warts often come back. Luckily Nature usually intervenes and, after a variable period, these annoying epidermal tumours disappear . . .

". . . Clearly if the mechanisms were understood it might be possible to influence less benign epidermal tumours that do not spontaneously regress. Their spontaneous disappearance . . . [presumably reflects] some immune reaction mounted by the host." *(Editorial. The Lancet. 1:1267, June 22, 1974)*

The Smoking Non-Smoker

"It is perhaps fortunate . . . for non-smokers [such as persons caught in a room filled with smokers] that tobacco smoke contains so many irritants. These make tobacco-smoke pollution intolerable long before concentrations are reached which would constitute a biological hazard. They usually ensure that the nonsmoker takes some protective action such as breath-holding or shallow breathing, opening a window, moving or leaving the room, or occasionally remonstrating with a smoker. Apart from the unborn child, the one non-smoker who cannot protect himself in this way is the infant at the mercy of his mother's smoke."
(Editorial. The Lancet 1:1201, June 15, 1974)

The Only Independent Weekly Medical Newspaper in the U.S.

Medical Tribune
and Medical News
Published by Medical Tribune, Inc.

"No-Knock" and No Nonsense

IN 1970, *Medical Tribune* opposed the passage of the Comprehensive Drug Abuse Prevention Control Act. The Senate passed it unanimously. *Medical Tribune* warned that the hysteria which was creating these new laws would come to plague us. The 1970 act lumped important therapeutic agents, both safe and effective, with dangerous drugs and narcotics. Thus, psychoactive drugs were stigmatized by association with heroin and cocaine. The law authorized the use of "no-knock" entry warrants. Subsequent regulations have become classic examples of how political expediency can exploit health problems. As a consequence of the drug hysteria, a new form of abuse has emerged—not the abuse of drugs but the abuse of rights of private citizens. As hysteria served political ends, news headlines stimulated the zeal of government drug agents, who broke into the homes of innocent families and added their deaths to those from drug abuse.

There is now a hue and cry for the repeal of the "no-knock" provision by the very legislators who voted unanimously for the law in 1970. A study of the subject reveals that the repeal of just the "no-knock" provision of *the law may* be a step backwards. Such repeal would not protect the public from overzealous police. On the contrary, it will remove a civil restraint which was introduced to limit the power of the government agents. Unbeknownst to most of us, physicians as well as public, is the fact that no-knock, *without a warrant*, has been a part of common law since the eighteenth century. The Comprehensive Drug Act added the requirement for a warrant issued by a judge for "no-knock" entry. Its repeal would leave us worse off than we were before.

Regardless of whether the focus be drugs or "no-knock," hysteria is no basis for legislation or regulation. There *is* a need for new law—a law which will make the drug enforcement agency of the Justice Department an agency for the control of illicit street drugs and *not* the control of doctors and their therapeutic drugs. After the last law was passed, a government official was quoted as saying, "What most people have overlooked is that this law creates a new drug regulatory agency, in addition to a strictly law enforcement agency." We have enough regulation of medicines with FDA. There is no need for another layer of bureaucracy in the regulation of doctors and their drugs.

The time has come to correct the regulatory nonsense and the abuse of the 1970 law. This can best be done by preserving the act's requirement of a warrant issued by a judge for any entry related to a drug case and by eliminating from the Comprehensive Drug Act therapeutic medicinals so that the regulatory focus of the Justice Department should be where it belongs, on the real problem—illicit, non-therapeutic, dangerous drugs and narcotics.

Let's have "no-knock" protection and no nonsense with medicinals.

A.M.S.

Hazards of the Unknown

AN EDITORIAL on this page eight months ago (Jan. 9, 1974) quoted an observation by molecular biologists at the 1973 Gordon Conference on Nucleic Acids that techniques were already available to unite "DNA from animal viruses with bacterial DNA, or DNAs of different viral origins might be so joined." Because of the fear that certain of the "hybrid molecules may prove hazardous to laboratory workers and to the public," the biologists urged that a "study committee be instituted to consider the problem and to recommend specific actions or guidelines."

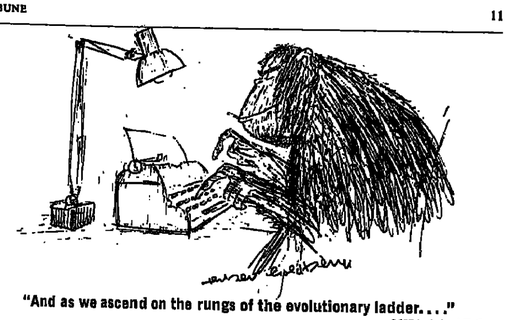
The National Academy of Sciences set up the Committee on Recombinant DNA Molecules. It should be noted that in the interim hybrid DNA molecules have been created that can, for example, "infect and replicate in *E. coli*."

The Committee has just called on scientists throughout the world to voluntarily defer the insertion of genetic determinants for antibiotic resistance or toxin formation into bacteria or the "linkage of all or segments of the DNAs from oncogenic or other animal viruses to autonomously replicating DNA elements such as bacterial plasmid or other viral DNAs." This restraint would await better evaluation of potential hazards or the development of methods to prevent their spread.

It seems certain that an international conference will be convened in February to consider the Committee's recommendations and how long the embargo on such genetic research should last. Some time ago (Jan. 13, 1969), we worried on this page whether genetic manipulation would unleash "dreadful forces" and urged that we "do all we can to foresee hitherto unforeseen consequences." It is high time we do so.

Clinical Nutrition

CLINICAL QUOTE: *"There is just no way to chart the amount of weight a patient has lost if you don't record it at the beginning. And if you don't know how much weight loss is involved, it is difficult to trace a problem to nutrition."* (Dr. Charles E. Butterworth, Jr. interviewed on nutritional status of patients in six Southeastern states. See Page 20).



"And as we ascend on the rungs of the evolutionary ladder. . . ."

LETTERS TO TRIBUNE

Speaking of Energy

One could have foretold what Economist Eliot Janeway would advise regarding the appropriately named "The Energy Ripoff" in his article on U.S. oil production (July 24), when he begins by stating that "William E. Simon brought a breath of fresh air into the great debate!"

He presents a brief through George Mitchell, president of an independent development corporation, for subsidizing independent developers to drill for the oil and gas which can still be obtained. This is to neutralize the strangle hold of "The Seven Big Sisters." These monopolies and multinationals also began as independents—and, like Topsy, grew by tax benefits-depletion allowances, import preferences and campaign contributions. Will the neo-independents remain as such?

If there are these untapped sources of energy abundant in our own country, not to speak of solar and nuclear energy, what about the real independents owning, developing and using them? Basically the people of this country!

HARRY E. BELLER, M.D.
Miami, Fla.

Chauffeur's Fracture in 1906

Your article "The Prevention of Chauffeur's Fracture," (Medical Tribune, May 8) made me look up old publications of my late father, Professor Dr. Richard Muchsam, Berlin. He published an article in *Deutsche Medizinische Wochenschrift*, 1906, #28, under the title (in German): "A typical injury of chauffeurs" which begins:

"The automobile, the most modern of vehicles, already causes a typical 'professional injury to the chauffeurs.' He, then, describes in detail the mechanism of starting the engine by hand with the crank, thus causing the 'typical injury of chauffeurs'."

The six page article, with x-rays and photos, describes the history, the findings, treatment of these injuries and ends with the following "hope":

"Perhaps progressing technique will give us a 'motor,' that accumulates during driving energy to start the car later on. That would be the best protection against 'the typical fracture-injury-of chauffeurs'."

EDUARD MUEHSAM, M.D.
New York, N.Y.

'Full Disclosure on PSROs'

May I thank you from the bottom of my heart for your editorial "Let's Have 'Full Disclosure' on PSRO's." Man, you have hit those hypocrites right where they deserve it.

I think you are being charitable when you say those physicians and scientists that you encounter in Washington are of "good faith." I am inclined to agree with the editor, Stan Evans, *Private Practice* magazine; he describes these people in Washington as people who are primarily interested in destroying private practice of medicine not to improve the quality of medicine, but to gain total power and control over it.

I wish there were some way to have your editorial of 17 July reprinted in *the lay press and drilled into the heads of those socialists and naive dreamers* who now control the A.M.A.

F. M. BALL, M.D.
Charleston, S.C.

Sexual Dysfunction

We are pleased that your journal is beginning to help spread word to doctors that a grent many people with sexual dysfunction are sick or at least have some kind of physiological abnormality that needs a physician to evaluate. We are in the process now of preparing several manuscripts which will point up this matter. We believe that it isn't in the too distant future that we will have medical means of treatment of a lot of problems that have been baffling and also avoided by physicians.

CHARLES W. LLOYD, M.D.
Milton S. Hershey Medical Center
Hershey, Pa.

Spouse Spouse Spouse Spou

Your major feature detailing the discriminatory slings and arrows hurled at women in—or attempting to enter—medicine (MT, August 7, 1974) is to be commended. But may I suggest a bit of self-examination?

The third sentence on FMGs in that same issue begins, "They and their *wives* . . ." (emphasis added). The young Swedish physician who attended my mother in a Manhattan hospital last summer was, in fact, wearing a wedding ring. But I doubt very much that she has a wife.

There is a perfectly good English word denoting a marriage partner of either sex: *spouse*.

DOPI SHULTZ
New York, N.Y.

General Practice Around the World

Dutch Doctor With 4,000 Patients Answers House Calls Under Threat of a Police Escort

Contrary to the impressions of some American physicians, not all foreign physicians are trying to get into the United States—many are quite satisfied where they are. With this report, MEDICAL TRIBUNE *begins a series of portraits of family practitioners overseas, taking a look at both their professional and personal lives.*

Medical Tribune World Service

ROTTERDAM, THE NETHERLANDS—When it is a house call, Dr. Dirk Van Leeuwen seldom hesitates. As a general practitioner, he is compelled by Dutch law to go to the patient, and if he is dilatory about it, he might find himself on his way to answer the call under police escort.

However, life in this tiny, crowded country is built on compromise. So Dr. Van Leeuwen does not find the number of house calls he receives—about 10 a day—excessive.

He knows which of his patients really need him, and the others can be convinced they should come in to see him the next day. "Anyway, there are far less house calls than there used to be," observes the 44-year-old G.P., "because more people have cars. Parents also understand now that they can bring a child with a temperature of 38°C in a car. There is far less chance that the child has a serious disease than in the early days of my practice when I had 30 or 40 calls a day."

Dr. Dirk Van Leeuwen with his wife, Dr. Johanna Van Leeuwen, who works with him. She will take over the appointment patients while he goes on his morning house calls.

First Line of Defense

Furthermore, he and his fellow G.P.s recognize the importance of their position in the health care delivery system. They are regarded by the authorities as the first line of defense—even hospitals take emergency patients directly only from accidents.

Dutch pragmatism borrows also from ancient China by paying Dr. Van Leeuwen for many of his patients even when they are well.

About 70 per cent of his 4,000 practice are members of the state compulsory health insurance fund which pays him 40 guilders (about $15) a head a year, whether they need care or not. Some 1,200 are his own private paying patients, those with incomes above the compulsory insurance limits, who pay according to a government scale of fixed fees.

This gives Dr. Van Leeuwen a gross income of some $69,000 a year. Official rental, staff, transport and other operational expenses take $27,000 of this, leaving him a net income of $42,000. But here comes the squeeze: the state takes 50 per cent of that in taxes, leaving him a net personal income of $1,750 per month.

The Dutch sense of organization is also evident in the building where Dr. Van Leeuwen has his office. This is a three-story stone building, formerly a railroad administrative headquarters now spruced up with furnishings and bright colors to serve as a health center for the area.

Here he and five other G.P.'s share one large waiting room, a reception service, and the administrative and records office where a color-coded patients' card file makes it easy for the duty doctor, when on rotation, to check the medical history of his colleagues' patients when on.

The group also share the staff of one graduate nurse and six medical assistants who have had two years training in reception, accounting, telephone, appointments scheduling and simple laboratory testing.

But each physician has his own patients and Dr. Van Leeuwen's have been booked solidly at eight an hour for his first morning session when he arrives at 7:30 or 8:00 A.M. At 9:30 when his wife and fellow G.P., Dr. Johanna Van Leeuwen arrives, she takes over the appointments and her husband goes down the hall for one of the two daily sessions which he calls his "little clinic."

Here he treats a child with a sore throat, a sailor with a wound to be dressed, "little ailments that are quickly treated and do not require the privacy of my office and treatment room," he explains.

Dr. Van Leeuwen brought this innovation with him from his own former individual practice and his colleagues in the group have all adopted it. Now the "little clinic" has people going in one door and out the other all day long as each of the group takes his turn there.

Twice a week, the morning coffee break is a staff meeting, for consideration of medical and administrative matters, but on the other days it includes informal chats with the social case workers and other professional staff who share the community health center.

Dr. Van Leeuwen, whose interest in medicine has always been patient-oriented, says he is glad to have the other social services for his patients within such easy communication distance.

"It makes it much easier for us to help solve the other problems related to their health. The social worker is just downstairs, so I can refer to her the mother who is upset over an eviction notice from one of the old apartment houses being torn down to make way for a new highway bridge and overpass. I can talk with the social 'Raadsman' who handles such problems, about my disabled patient who is having a hard time finding a job."

Other facilities at the center include a cafeteria which provides a hot meal a day at token prices for the community's elderly. A mother-baby clinic, staffed by a nurse and, for a few hours a day, a physician, gives nutrition advice and inoculations.

Wife Exempt From Night Duty

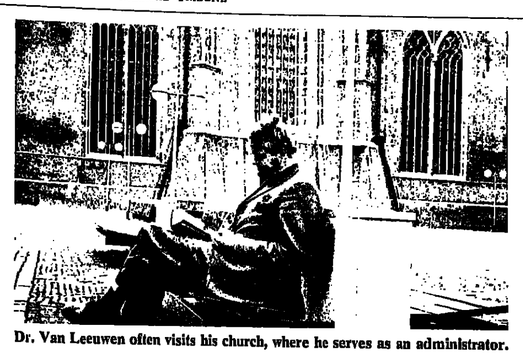
Night duty, which falls on Monday, the Drs. Van Leeuwen do not share. The group considers them to have one practice, so Dr. Johanna Van Leeuwen is exempt, though she does work with him during Saturday office hours—3 sessions at 10 a.m., 1 p.m. and 5 p.m.—when he takes his every fifth weekend duty. Duty weekend Sunday includes two office sessions, at 1 p.m. and 5 p.m. On Monday nights he remains at the office for urgent consultations until midnight when an automatic telephone takes over to refer patients to his home phone or the extension in his car.

On other evenings, Dr. Dirk Van Leeuwen can be found chairing a workshop on community health workers which makes recommendations for improvement of the health system, presiding over a medical study group, attending a monthly clinical workshop, or meeting with the pastor and other administrative board members of his local church. "It is all a matter of organization," he shrugs when asked how he fits everything in.

There is still time now and then for a quiet family meal with their three children in their lakeside home in the Rotterdam suburbs. They also have a weekend cabin by the sea, where Dr. Van Leeuwen has more space to indulge his hobby of flower gardening.

The Van Leeuwens take two months of vacation a year. The summer half is usually spent at the sea-side cottage. But now that the children are growing up, the past two summer vacations have been spent on cycle trips around Holland. This summer the Van Leeuwens are taking their five bicycles to Britain for a month of camping around the English countryside.

Winter vacations include a two-week ski trip, usually in Austria, with the remainder taken a few days at a time for continuing educational courses—of which there are many in Rotterdam and which the Drs. Leeuwen always attend together.



Dr. Van Leeuwen often visits his church, where he serves as an administrator.

Dr. Van Leeuwen, with one of his group's six assistants, checks the record of a colleague's patient whom he will see during his duty weekend.

Cycling is the favorite sport of the Van Leeuwen family. Their summer vacation was spent pedaling and camping on a long tour through the Britain countryside.

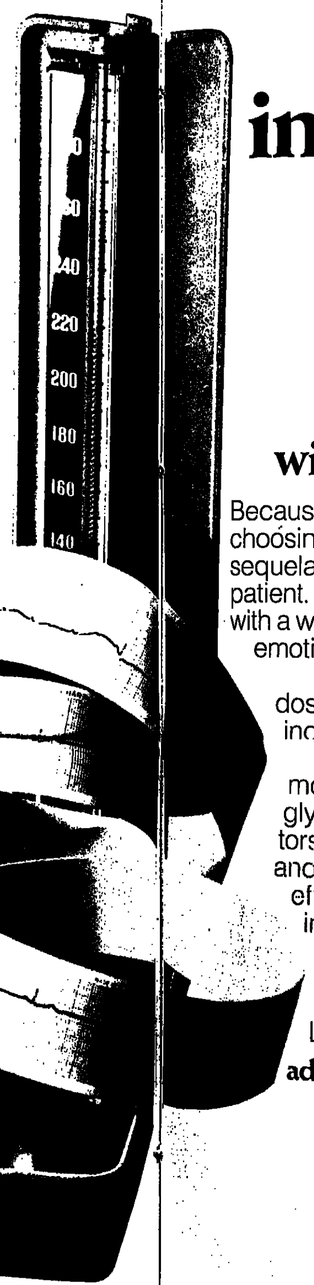
Dr. Johanna Van Leeuwen becomes mother, housekeeper, and cook beginning at 4:00 P.M., when the children return from school.

Dr. Dirk Van Leeuwen in the group's "little clinic," where patients come without appointment to be treated for minor ailments not requiring privacy.

Flower gardening is one of Dr. Van Leeuwen's hobbies. Above, he shows one of his children a prized tulip in the garden at their summer cottage near the sea.

Dr. Van Leeuwen on house call. He makes about 10 such calls a day. They are scheduled in two separate periods, one in the morning and one in the afternoon.

The Somatic Protest in the Hypertensive Patient



Physiologic reaction to excessive anxiety

A disproportionate emotional response, such as excessive anxiety, may trigger or aggravate symptoms in the patient with essential hypertension. For example, among its adverse effects on the cardiovascular system are tachycardia, cardiac arrhythmias and elevation of blood pressure in susceptible patients.

Thus, control of excessive anxiety becomes an essential part of total medical management of the hypertensive patient. For some, counseling and reassurance are sufficient to reduce harmful anxiety, but often adjunctive use of appropriate antianxiety medication is necessary.

Antianxiety action with wide margin of safety

Because of the growing number of antianxiety medications, choosing an effective adjunctive agent with relatively few adverse sequelae would be most desirable for use in the hypertensive patient. Librium has a long clinical record of prompt *effectiveness* with a wide margin of *safety* in relieving deleterious anxiety and emotional tension.

In the elderly and debilitated, the initial recommended dosage is 5 mg *b.i.d.* or less to preclude ataxia or oversedation, increasing gradually as needed and tolerated.

Librium is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensive agents and vasodilators. Although clinical studies have not established a cause and effect relationship, physicians should note that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and Librium. Recent studies have shown, however, that Librium does not impair the action of the widely used coumarin anticoagulants.

After anxiety has been reduced to tolerable levels, Librium therapy should be discontinued.

adjunctive

Librium® 10 mg (chlordiazepoxide HCl)

ROCHE

1 or 2 capsules t.i.d./q.i.d. for moderate to severe anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

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3 Flexible Prophylactic Plans Geared to Asthma's Severity

Medical Tribune Report

CHICAGO—Three different flexible prophylactic programs for chronic asthma of varying severity, each specifically designed to stay "one step ahead" of significant airway obstruction, were described to the Allergy Section of the American Medical Association meeting here.

Each of the three types of inhalant medications—adrenergics, steroid aerosols, cromolyn sodium—is useful prophylactically, but in different doses and sequences tailored to the severity of the patient's asthma, according to Dr. Constantine J. Falliers of Denver.

Dr. Falliers, Director of the Allergy and Asthma Clinic, and attending allergist at the National Jewish Hospital and Research Center in Denver, bases his program on the past five year's experience with outpatients and with more severely ill, hospitalized children.

He divides patients into three treatment groups:

- Group A, mild to moderate asthma that is increasing in severity;
- Group B, variable intermittent or seasonal asthma;
- Group C, severe asthma, improving with therapy.

For Group A patients, "Adrenergic aerosols can be used in an anticipatory way, as the method of first choice to prevent asthma from becoming a daily, disabling disturbance," Dr. Falliers said. Three to ten inhalations a week usually maintain patients symptom-free, and without dependency reactions.

If more than ten weekly inhalations are needed, Dr. Falliers recommended consideration of cromolyn sodium as the next step. "If that fails, systemic corticosteroids, in adequate doses, for a few days, will introduce a maintenance program of inhalational steroids."

Suggested Sequence of Treatments For The Prophylaxis* of Asthma

A. Mild-moderate asthma but increasing in severity & frequency

Rx (1) Bronchodilator aerosols p.r.n.
(2) Cromolyn Na inhalations b.i.d.—q.i.d.
(3) Corticosteroids, systemically, then aerosols topically q.d.—q.i.d.

B. Variable intermittent or seasonal asthma

(1) Cromolyn Na inhalations q.i.d.—q.d.
(2) Bronchodilator aerosols p.r.n.—q.i.d.
(3) Short courses of corticosteroids p.r.n. orally or aerosols

C. Severe asthma but improving with therapy

(1) Systemic corticosteroid bronchodilators
(2) Corticosteroid aerosol inhalations, q.i.d.—q.d.
(3) Corticosteroid aerosols + cromolyn Na (still under study)
(4) Cromolyn Na + bronchodilator aerosols p.r.n.
(5) Bronchodilator aerosols p.r.n.

Priorities* in the Selection of Prophylactic Aerosols for Asthma

Desired Effect	Adrenergic Aerosols	Cromolyn Sodium	Corticosteroid Suspensions
Immediate action: (Sx present)	1	0	2
Short-term protection (no symptoms)			
a) Isolated exposures	1	2	0
b) repeated exposures	2	1	3
Extended prophylaxis (seasonal, perennial)	3	1	2
Avoidance of sympathetic stimulation	(−)	1	2
Avoidance of systemic steroids			
a) adrenergically responsive Ss	1	2	3
b) adrenergically refractory Ss	(−)	2	1
Control of severe "steroid-dependent" asthma	0 or (−)	0 or 2	1

1—first; 2—second; 3—third choice
0—not indicated; (−)—contra-indicated
*Prophylaxis with oral drugs, hyposensitization injections and/or avoidance of allergens not included.

Cromolyn Sodium for Group B

For Group B patients, therapy starts with oral medications—bronchodilators and steroids—in preparation for cromolyn sodium as the prime inhalant medication, with adrenergic aerosols as second adjuvant, and aerosol or oral steroids if needed.

For Group C patients, the first step must be normalization of pulmonary function with systemic steroids and bronchodilators. "Once this goal is achieved, inhalational corticosteroid therapy with a water-insoluble preparation, such as triamcinolone acetonide, can be introduced."

After weeks or even months of successful therapy, "an attempt can be made to reduce the dose to levels below maintenance, and use additionally, adrenergic bronchodilators, in order to prevent relapse. The data on the possible combination of corticosteroid inhalations with cromolyn sodium are not sufficient, yet, to permit any definitive recommendations."

Citing specific advantages and drawbacks to each form of inhalant therapy, Dr. Falliers noted that adrenergic aerosols are most useful when patients are not in serious respiratory difficulty.

Cromolyn sodium inhalants—though pretreatment is able to block immediate, acute reactions to known allergens—may take a long time to improve the asthmatic situation. Very effective in a majority of patients, totally ineffective in others, Dr. Falliers reported that young, atopic patients without frequent respiratory infections, who show no serious pulmonary function changes, are most likely to respond positively. But before prophylactic cromolyn therapy is started, he stressed, patients must be adequately treated to normalize pulmonary function.

Dr. Falliers restricts triamcinolone acetonide aerosol—which is still investigational in the United States—to patients who are dependent on oral steroids to control their severe, intractable asthma. "One of the criteria for effectiveness was the ability to reduce and discontinue oral steroids under triamcinolone prophylaxis," he told the meeting, adding that this was accomplished in 20 out of 22 patients within five weeks.

Marked Improvement Reported

In these patients, previously suppressed cortical functioning returned to normal range, pulmonary function tests improved—though sometimes not until the fourth week—and daily inhalational doses were consistently less than 1/20th of the oral dose previously required to achieve less satisfactory asthma control.

"Clinical evaluation and subjective responses in all cases treated for four weeks or more indicated a marked increase in physical fitness, in exercise tolerance, and a general freedom from asthmatic symptomatology, as compared to the pretreatment status of each patient."

Trichinosis in Japan

Medical Tribune World Service

KYODO, JAPAN—Trichinosis was contracted by 14 local hunters here who ate raw slices of the meat of a boar shot during a hunting expedition.

This is the first known case in Japan of human beings being affected by trichinosis.

Vaccine Supply Short in Brazil Meningitis Epidemic

Medical Tribune World Service

SAO PAULO, BRAZIL—Health officials fighting an epidemic of cerebrospinal meningitis here report that they are facing shortages of vaccine.

Already more than half a million cases of both type A and type C of the disease have been reported in the state of Sao Paulo alone with about 400 deaths. The epidmic, which is seasonal, is exceptionally severe this year, and is not expected to peak out until the end of August. The epidemic has caused Uruguay to order its border with Brazil closed.

At Lyons in France, staff at the laboratories of the Merieux Institute have been recalled from vacation to help boost production of the type A vaccine. Staff at the Institute pointed out to Medical Tribune that the industrial production of the vaccine was scheduled to begin only at the end of this year. "Now we are racing against time to produce the volume requested," a spokesman said.

About 400,000 doses have already been airlifted and staff are now working to turn out more than a million doses by the end of August. Hospital staff in Brazil have indicated that about half the cases they are seeing are type A.

Vaccine for type C, produced only in the United States by Merck Sharp and Dohme, is said to be in even shorter supply. Public health staff in Sao Paulo have asked for some three million doses, but to date have only received about 200,000. The company hopes to begin shipping the remainder in September.

A child with meningitis is rushed to a hospital in São Paulo. The spreading epidemic has prompted officials to order vacationing city schools to remain closed.

NRC Proposal Renews Row Over Food Fortification

Continued from page 1

by the NRC's Food and Nutrition Board, were prepared under contract with the FDA, and would require the addition of 10 vitamins and minerals to foods made of wheat, corn and rice. The added nutrients would include vitamin A, thiamin, riboflavin, niacin, vitamin B_6, folacin, iron, calcium, magnesium and zinc.

U.S. Government regulations currently permit a manufacturer to identify flour as "enriched" if thiamin, riboflavin, niacin and iron are added, and 34 states now require that flour and bread be so enriched. Similar programs are in effect in a more limited way for cornmeal, some macaroni products and rice.

The NRC panel is now proposing that all cereal grain-products be enriched with these and the six additional nutrients that, it says, are needed "by significant population groups that face potential nutritional risk." The report stressed that the technical feasibility of adding some of the nutrients has not yet been determined. It has urged cooperative studies among industry, governmental agencies and other interested parties to determine the stability of the nutrients, their availability, uniformity of dispersion, freedom from separation in commercial handling, and color, flavor and odor in relation to consumer acceptance.

Major Modification by FDA

Dr. Chopra noted that a major modification made in the NRC proposals by the FDA calls for a differentiation between ready-to-eat and hot cereals, and proposes separate guidelines for each.

Whereas the NRC developed its guidelines in terms of overall nutritional requirements, she commented, the FDA's recommendations were mapped "from the point of view of the product. We considered in detail what the food is to be used for, and what it is deficient in."

Likely to arouse the greatest controversy, if the dispute over iron in bread is any indication, she acknowledged, is the FDA's proposal to fortify hot cereals with iron at 8.1 mg. per ounce of the dry uncooked product. This is nearly double the NRCs' recommendation.

"There is definite evidence of the likelihood of shortage of iron, and possibly calcium in the diets of those who commonly consume hot breakfast cereals," says the FDA recommendation, as published in the *Federal Register*. The evidence cited is that contained in the Ten-State Nutrition Survey, and the 1965 USDA Consumption Survey.

Dr. Chopra commented that the FDA is also calling for the mandatory addition of magnesium to hot cereal products, whereas the NRC is inclined to leave this optional.

In another modification of the NRC's recommendations, the FDA is proposing that iodine should not be listed as a required nutrient in cereals. Dr. Chopra noted that the use of iodine needs further study since the substance may pose serious organoleptic and stability problems.

Differ on Presweetened Cereals

The FDA also differs with the NRC food board on the issue of presweetened cereals. Where the NRC believes that presweetening results in undue dilution of cereal nutrients with sugar, the FDA takes the position that presweetened cereals contribute only a small amount to the consumer's intake of sugar and "in some cases only replace sugar that would be added by the consumer."

This clause is likely to generate even further controversy from such consumer advocates as the Ralph Nader-affiliated Health Research Group which has called for a total ban on sugar additives in cereals.

Dr. Vergil Wodicka Director of FDA's Bureau of Foods, told MEDICAL TRIBUNE that he expects it will take at least a year before any of the recommendations are implemented.

"What we are proposing are extremely preliminary concepts," he said. "A lot of opinions will have to be taken into account before we act."

Acknowledging that some controversy is inevitable, he said:

"The ball is in our court. We're the action agency. We'll either have to return the ball or ignore it. In either case it will have to be a conscious decision."

Medicine on Stamps

Jean Baptiste van Helmont

Born in Brussels in 1577, he studied philosophy, law, and medicine, receiving his M.D. from Louvain in 1599. Trying to explain all body processes in chemical terms, he founded the iatrochemical school. He devised a thermometer, was the first physician to make gravimetric studies on the urine, described gastric digestion in terms of fermentation, and observed the root of asthma to be in the bronchi.

Text: Dr. Joseph Kiss
Stamp: Minkus Publications, Inc., New York

One Man...and Medicine

A GUEST COLUMN BY ALTON OCHSNER, M.D.
MEMBER, MEDICAL TRIBUNE ADVISORY BOARD

My Experience in Introducing Blood Transfusion into Europe

[Dr. Ochsner is also Consultant in Surgery, Ochsner Clinic and Alton Ochsner Medical Foundation, and Emeritus Professor of Surgery, Tulane University School of Medicine, New Orleans.]

BLOOD transfusion has been used frequently only in the last 35 to 40 years, although Landsteiner[1] in Vienna in 1900 discovered the three main blood groups in man and published his findings in 1901. In 1902 Descastello and Stirli[2] described a fourth blood group, and in 1907 Jansky[3] published a numerical classification of four blood groups in a Bohemian journal. However, transfusion was not generally accepted in Europe, and very few, usually unsuccessful, were performed. In the United States, Moss[4], working independently at Johns Hopkins, developed a numerical classification of four blood groups and published his findings in 1912. Thereafter, transfusions were done safely in the United States using compatible blood, but few were performed.

I got my original surgical training in the early '20s in the Augustana Hospital in Chicago, where Dr. A. J. Ochsner was chief surgeon and Dr. Nelson Percy his associate. In this institution in the early '20s, many transfusions were done because of Dr. Percy's interest in pernicious anemia. As was not infrequent at that time in maladies of unknown cause, Dr. Percy postulated that pernicious anemia was caused by foci of infection and advocated removal of all foci of infection —the teeth, the tonsils, the gallbladder, the appendix. Because all of these patients had large spleens, splenectomy was also performed. Blood transfusions were required to prepare the patients, markedly anemic, for the operation. For this reason, we performed many transfusions during my training, and we all became very adept at it.

Preparing for Transfusion

The method Dr. Percy used was a modification of the Kimpton-Brown tube, which is a paraffin-lined cylindrical tube. The lower end of the tube was drawn out into a cannula that could be inserted into the veins of the donor and the recipient. The tube was sterilized in a hot-air sterilizer, with melted paraffin being drawn into the tube, which was rotated before a fan so that a thin coating of paraffin was deposited on its inner surface. The tubes were kept sterile in sterile towels.

When a blood transfusion was done, cutdowns were made in the antecubital fossa of a compatible donor and recipient. A small amount of sterile liquid paraffin was drawn into the tube before introducing the cannulated end of the tube distally into the lumen of the vein of the donor, and by using a bulb to apply negative pressure on the upper end of the tube, blood was drawn into the tube. The blood therefore touched only the paraffin, the liquid paraffin on top and the solid paraffin on the walls of the tube. It was possible in this way to obtain 600 or 700 cc. of unaltered blood. The cannula was immediately introduced into the vein of the recipient, with the cannula directed toward the cardiac side. By means of a bulb, gentle pressure was exerted at the upper cannula, and the blood was forced into the recipient's venous system. This was a very satisfactory way of giving unaltered blood. Astonishingly few reactions resulted, even though blood cross matching had not been done. The donor was of the same blood group or a universal donor.

Off to Europe

After I had finished my training, Dr. Ochsner arranged for me to go as an exchange surgical resident to Zurich, Switzerland, under Professor Clairmont for a year and then for two years under Professor Schmieden in Frankfurt am Main, Germany. Before I left in September, 1922, Dr. Ochsner told me that I should take test sera and a blood transfusion tube because the Europeans did not use blood transfusions. This was hard for me to understand, as the Swiss and German surgeons were so far advanced medically. After a very rough Atlantic crossing that made me very sick, I arrived in Hamburg, Germany, with the test sera and the well-protected transfusion tube. It was quite an oddity to the surgeons when I arrived at the clinic.

The University of Zurich Surgical Clinic, in the Kantonsspital, was a very active service with many patients who needed blood and, in fact, died without it. When I asked why transfusions were not done, I was told that they were too dangerous. In the preceding year five transfusions had been done, and three of the patients died from reactions. They used no blood grouping or matching but employed the Biologishche Probe, the biologic test. This consisted of giving the patient 20 to 25 cc. of blood, and if he did not die, he was given the transfusion. It was quite frustrating to me to see people dying unnecessarily, when I knew that they could be saved by the use of blood.

My First Case

About three months later, a notorious criminal was admitted with a gunshot wound through his femoral artery. Completely exsanguinated, he was in extremis. The *Oberarzt*, who had become my friend, told me that I could transfuse him, because if he died, it would make no difference. I quickly obtained a compatible donor, transfused him, and he promptly recovered. Although elated at this success, I was reminded that two of the five patients transfused the year before (without preliminary grouping) had also survived. I felt that I could not win.

But that afternoon a prominent banker who was a very good friend of Professor Clairmont's was admitted bleeding massively from a duodenal ulcer. He was so exsanguinated that it was impossible for him to be operated upon, and it looked as if he would die. Professor Clairmont came to me with tears in his eyes and asked me if I could give him blood safely. I told him that he would not die as a result of blood, but I was sure he was going to die without it. He then gave me permission to transfuse him. I was able to give the patient 1,300 cc. of blood within about 20 minutes. He was then operated upon by Professor Clairmont, and he got well. These two successes in such a short period of time brought about a complete alteration in their feeling about transfusion.

A Transfusion Psychosis

We even began using transfusion to treat many conditions for which it was not needed. I remember that the *Oberartz* postulated that by exsanguination and transfusion one might cause a regression of cancer. We had a patient with a large inoperable cancer of the stomach whom we repeatedly bled and transfused. After many transfusions, he developed a psychosis, and whenever he saw a young, virile-looking individual he wanted to get blood from him. The man improved considerably for a time, but then his condition deteriorated and he finally died.

I then went all over Europe giving transfusions and became *the* blood specialist. My first publication was in German, "Die Bluttransfusion nach Percy," in the *Wiener Klinische Wochenschrift* in 1923.

Transfusion in the United States

Blood transfusions, however, were still infrequently used in the United States. In January, 1927, I was asked by Tulane to come to New Orleans to be considered as a possible successor to Dr. Matas. Every Friday, Dr. Matas operated on charity patients at Touro Infirmary. I visited him on Thursday to see his cases and one was a patient who had multiple neurofibromatosis, one on her back weighing more than she did. She weighed 90 pounds after the tumor was removed, and the tumor weighed 92 pounds.

I was intrigued. How would Dr. Matas be able to handle this enormous tumor? A man of great ingenuity, he had a block and tackle put in the ceiling of the operating room. The patient was put to sleep and then turned in the supine position. The area was prepared; then a pair of sterile ice tongs was thrust into the tumor, which was attached to the block and tackle, and the tumor elevated, leaving the patient suspended by its pedicle. Two Wyeth pins, steel pins about the size of an ordinary pen, were introduced in the pedicle of the tumor, producing four quadrants. A tourniquet was placed on the patient's side of the pins, the pins keeping the tourniquet from slipping off. It was then relatively simple to remove the tumor with little visible loss of blood.

Dr. Matas had been the first to use intravenous saline surgically, and during the operation, the patient was given a drip of intravenous saline. Immediately after the operation, the patient was in good condition, but that night she died of hypovolemia because most of her blood had been trapped in the tumor. Had transfusion been available at that time, the patient would have survived. I mention this merely to show that as recently as 1927 in the United States, where transfusions were accepted and done, they were done infrequently in a large surgical clinic in New Orleans.

The world owes a great deal to Landsteiner and his original work on the grouping of blood, showing that for a transfusion to be successful and safe the bloods must be compatible, a concept emphasized even more recently in doing organ transplantations.

References

1. Landsteiner, K.: "Ueber Agglutinations erscheinungen normalen menschlicen Blutes," *Wein. Klin. Wschr. 14:* 1132, 1901.
2. Descastello, A., Stirli, A.: "Ueber die iso-agglutinine im Serum gesunder und kranker Menschen," *Munchen Med. schr. 49:*1090, 1902.
3. Jansky, J.: "Hamatologicke studie in psychoiku," *Sbornik Klin. 8:*85, 1907.
4. Moss, W. L.: "Studies in isoagglutinins and isohemolysins," *Bull. Hopkins Hosp. 37:*63, 1910.
5. Ochsner, A., Nather, K.: "Die Bluttransfusion nach Percy," *Wien. Klin. Schr. 36:*687, 1923.

It is the lone worker who makes the first advance in a subject: the details may be worked out by a team but the prime idea is due to the enterprise, thought, and perception of an individual.

Sir Alexander Fleming (1881-1955)
Address, Edinburgh University, 1951

Leukocyte Migration Test Predicts Exophthalmos

Medical Tribune World Service

PRAGUE—A leukocyte migration test to retrobulbar extracts should be used when drug therapy is contemplated for thyrotoxic patients, Dr. R. J. Winand, of Liège University, Belgium, warned at the Sixth annual meeting of the European Thyroid Association here.

Exophthalmos in 50 of 433

Reporting on the use of radioiodine or antithyroid drugs in 433 patients over a two-year period, Dr. Winand said that malignant exophthalmos occurred in 50. Using a leukocyte migration test, he found a correlation between exophthalmos and the presence of antigenic material of retrobulbar extracts.

Because of these results, he decided to use the leukocyte migration test as a prognostic test, and all further patients with this positive result were treated with an immunosuppressive drug (azathioprine, 1.5 mg./Kg.). The next 100 patients with combined treatment—immunosuppressive and antithyroid with a positive leukocyte migration sign—showed no single case of exophthalmos.

Iatrogenic Malnutrition Held Widespread

Medical Tribune Report

BIRMINGHAM, ALA.—Many patients in big-city hospitals across the country are suffering from iatrogenic malnutrition, and some have actually died of starvation, according to the chairman of the American Medical Association's Council on Foods and Nutrition.

Dr. Charles E. Butterworth, Jr., who is also Professor of Medicine and Pediatrics at the University of Alabama in Birmingham Medical Center, said in an interview here that food in hospitals is usually adequate, but that many physicians are guilty of withholding meals from patients and failing to provide nutrition supplements and other essential diet components.

In a study based on experiences in six Southeastern states, Dr. Butterworth charged that too many patients are undernourished and physicians have to take part of the blame.

I.V. Patients Worst Off

"Any physician who can recognize the symptoms of malnutrition will have plenty to observe if he will look around any big-city hospital. While the food served to a majority of patients is generally good, it's the ones who are fed through I.V.s who are most often subject to malnutrition. Too many physicians overlook the nutrition requirements when it comes to these patients. And in many cases, doctors are guilty of overusing low calorie content fluids like glucose and saline," he said.

While principals of good nutrition are practiced by some individuals, Dr. Butterworth said, it appears to be the exception rather than the rule.

"I believe it is incorrect for the public or the medical profession to assume good nutrition is automatically provided to hospitalized patients in the U.S. This is particularly disturbing considering the technological advancements that have been made in many highly specialized areas, including dietetic care.

"It's about time doctors start putting the basic nutrition principles to work. It is certainly vital to good patient care to look at such matters as caloric requirements, vitamin and mineral equilibrium and protein requirements under the stress of injury or infection."

Of 80 patient charts scanned in Dr. Butterworth's study, 30 per cent were suffering from malnutrition during hospitalization, and at least one patient, a 52 year-old man recovering from apparently successful open heart surgery for correction of aortic and mitral valvular heart disease, died of starvation on the 83rd postoperative day.

Calling the patient a "classic case of iatrogenic protein-caloric malnutrition which resulted in terminal starvation," Dr. Butterworth said a review of records showed the man had not received any oral vitamin supplementation for the 35 days he spent in the hospital's medical intensive care unit.

Another area of concern in the nutrition picture is what Dr. Butterworth called "the unwarranted reliance on antibiotics" in hospitals.

Protein Needed for Antibodies

"We know from studying malnutrition in underdeveloped countries that the body cannot produce antibodies without sufficient protein. There are times when doctors prescribe antibiotics for patients with abscesses or wounds, and forget to figure nutrition in the picture," he said. "Of course antibiotics are needed to fight infection, but protein is needed to heal the wound. They have to work together, and I believe many physicians have lost sight of this vital requirement."

One of the most disturbing disclosures of the study, Dr. Butterworth declared, is that simple procedures in the nutritional aspects of patient care are not being followed.

"There are a lot of simple things we know how to do, but they are just not being done. We found that more than 30 percent of the patients in our study had not been weighed when they entered the hospital. There is just no way to chart the amount of weight a patient has lost if you don't record it at the beginning. And if you don't know how much weight loss is involved, it is difficult to trace a problem to nutrition," he said.

Other undesirable practices affecting the nutritional health of hospital patients, Dr. Butterworth continued, include failure to observe patients' food intake, ignorance of the composition of vitamin mixtures and other nutritional products, failure to recognize increased nutritional needs due to injury or illness and the delay of nutritional support until the patient is in an advanced state of depletion, which is sometimes irreversible.

"There is a definite need for a concentrated effort on the part of medical educators to keep medical students and physicians informed on the nutritional aspects of patient care," he stressed, "and there has to be better coordination between doctors, dietary personnel and nurses who administer bedside care, to ensure good nutritional practices in our nation's hospitals."

VD Up in Austria

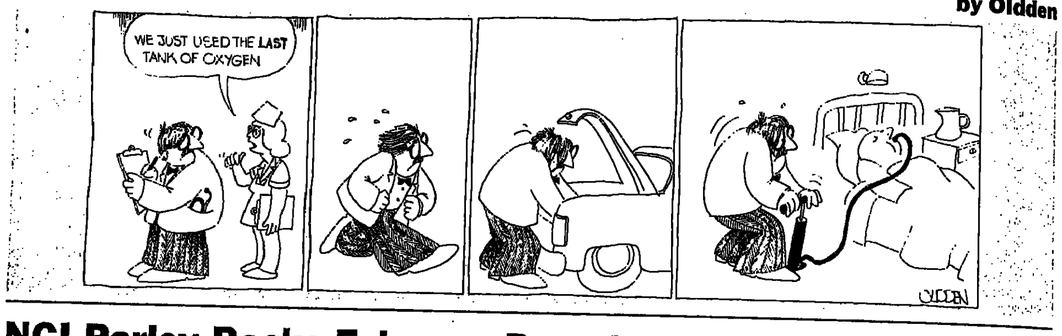
Medical Tribune World Service

SALZBURG, AUSTRIA—Venereal disease affects about 100,000 people in Austria, according to an estimate by Dr. Josef Soeltz-Szoets of Salzburg University Clinic. This is the highest figure since the war.

Apart from the classic diseases, gonorrhea and syphilis, Dr. Soeltz-Szoets said, recent estimates indicate that 20 per cent of the adult female population is affected by trichomoniasis.

Clinical Trials

by Oldden



NCI Parley Backs Estrogen Receptor Assay

Continued from page 1

where the primary lesion was estrogen-receptor positive, subsequent metastatic lesions would be also.

He suggested that "estrogen receptor values taken at the time of the original mastectomy might be useful in determining whether some sort of endocrine therapy should be included in the adjuvant regimen."

Dr. Elwood V. Jensen, of the Ben May Laboratory for Cancer Research, University of Chicago, said that his findings suggested that perhaps patients who are estrogen-receptor negative should not be adrenalectomized. It might be better, he said, to start chemotherapy immediately, "rather than insult the patient with major surgery and then wait six months while the cancer gets a further head start."

Dr. Albert Segaloff, of the Division of Endrocrinology, Alton Ochsner Medical Foundation, New Orleans, said "we should realize that hormonal therapy may shortly start along with primary therapy—although at the moment we are not optimistic enough to think that today we are going to use hormonal therapy as primary therapy."

The estrogen-receptor assay "may give us a handle on an adequate stratification of primary patients—along with other hormonal and biochemical parameters—so that we can set up much more meaningful attempts at adjuvant hormonal therapy.

"In our present state of knowledge," he added, "primary treatment still achieves very few cures, although we do improve the quality and quantity of life for many of our patients. Our problem now is to find the patient with clinically recurrent disease as early as possible so that we may start treatment when the host has the lowest tumor burden and, hopefully, we have the greatest chance of success."

Dr. Jensen said that his experience, like that of other investigators at the conference, showed that between one-third and one-half of all breast cancer patients demonstrate estrogen-binding capacity. Of this group, between 60 and 70 per cent can be expected to respond to endocrine therapy.

Estrogen-binding capacity varies considerably from patient to patient, and "a strong relationship seems to exist between estrogen receptor titer and response," according to Dr. Edwin D. Savlov, University of Rochester School of Medicine and Dentistry. "In our group, the patient with the highest value of receptors has been in complete remission of soft tissue metastases on estrogen therapy for over one year."

'Have to Sharpen Technique'

Dr. Jensen also confirmed this experience, noting that most of his non-responding positives occurred in the middle range of estrogen-binding capacity.

"I think we are going to have to sharpen our technique a little and decide just where we are going to establish the dividing line between positive and negative to give us the best chance to eliminate" patients who are not likely to respond to hormonal therapy, he said.

Dr. McGuire said he was encouraged by the fact that differences expressed during the conference had been "shades of gray rather than black and white," but there was a major problem to be overcome before the estrogen receptor assay could be put into widespread use.

"There are some 80,000 new cases of breast cancer a year in this country alone," he said. "If this technique is to be recommended—not necessarily officially by a committee or by the American Cancer Society—but if it becomes a community standard, who is going to do these 80,000 samples, how are they going to do them, and how is quality control in the laboratories going to be assured?"

He urged the development of an assay technique that would be simpler than those now in use and that would have quality control built in.

Summing up the meeting, Dr. Carbone said he found the results "encouraging" and noted that NCI was anxious to support further research in this area—particular blind clinical trials. He said NCI had set up an assay lab for use by investigators.

"We need more information about males and about differences in ethnic groups," he said, "and we also need more information about multiple biopsies done in the same patient at the same time, because there seems to be some suggestion that some cancers may be both positive and negative at the same time, and this would make them difficult to treat."

"Basically, however," he said, "I think we're encouraged."

Estrogen Receptor Data

Ablative Therapy	ER+	ER−	ER±
Castration	28/43	2/74	4/6
Adrenalectomy	40/76	4/41	2/6
Hypophysectomy	9/14	0/12	0/2
Total	77/133	6/127	6/14
Additive Therapy			
Estrogens	38/60	2/49	0/1
Androgens	10/28	2/22	[illegible]
Glucocorticoids	16/32	0/19	[illegible]
Adrenalectomy	[illegible]	[illegible]	[illegible]
Castration	[illegible]	[illegible]	[illegible]
Hypophysectomy	[illegible]	[illegible]	[illegible]
Total	[illegible]	[illegible]	[illegible]
Grand Total	[illegible]	[illegible]	[illegible]

These figures represent the total experience reported at the estrogen receptor conference, as tabulated by Drs. Mary E. Sears, NCI, George Escher, Scarsdale, N.Y., and Albert Segaloff, Alton Ochsner Medical Foundation. They represent raw data, some of which have been subjected to the peer review process organized by Drs. Sears and Escher, some of which have not. The figures before the slash represent patients demonstrating an objective remission; figures after the slash total patients treated.

Dr. Griner Disputes Claims Made for Special-Care Units

Medical Tribune World Service

TORONTO—Doubts about the validity of the claims made for coronary unit intensive care units were expressed by an American physician at the annual meeting of the Canadian Medical Association here.

The widespread use of such units has probably reduced inhospital mortality from myocardial infarction, but the gains have been rather modest, in the view of Dr. Paul F. Griner, Professor of Medicine at the University of Rochester.

Data from the best-designed studies are conflicting, he observed.

A review of hospital mortality from myocardial infarction now and ten years ago suggests that perhaps 10 more patients out of every 100 admitted with myocardial infarction are leaving the hospital today, Dr. Griner said. A reasonable estimate, he said, would be an over-all reduction in mortality of from 30-35 percent in the early 1960s to 20-25 percent in the 1970s.

Even if this reduction could be attributed wholly to the principles inherent in coronary care units, the gains have been more modest than generally believed, he commented.

Turning to intensive care, Dr. Griner declared there has been a dearth of studies. It seems, he said, that the gains expected from coronary care were extrapolated to this broader area.

A retrospective study has therefore been conducted at the Strong Memorial Hospital, Rochester, in which the progress of patients admitted with a diagnosis of acute pulmonary edema has been compared before and after the opening of an intensive care unit.

The only striking difference in the outcome of their treatment has been a 46 per cent increase in the average hospital charge, Dr. Griner stated. Hospital inflation accounted for only 10 per cent of this increase.

He said that he and his colleagues concluded that the initial treatment in the emergency room was almost certainly a greater determinant of the patient's survival than was the subsequent hospital location. As a result of this study and a review of the annual mortality for the five years preceding it, only the most seriously ill patients with acute pulmonary edema are now admitted to the intensive care unit.

Another study of patients admitted in coma from drug overdose produced a somewhat different conclusion. Patients who received intensive care had the same survival rate as those who did not, but their hospital stay was shorter, with fewer complications. There was also a greater educational input for nurses and house officers in the respiratory care unit setting.

Dr. B. W. Kirk, director of the I.C.U. at Winnipeg (Man.) General Hospital, who had been asked to speak in favor of intensive care, said he agreed with Dr. Griner that the impact of such units has been more modest than some have claimed.

"Nevertheless, coronary care probably makes a 10 per cent difference in mortality from acute myocardial infarction," he said.

TRIBUNE'S FORTNIGHT REPORT

Tennis Elbow No Misnomer; Found in 13% of 84 Experts

Medical Tribune Report

STANFORD, CALIF.—"Tennis elbow," even by the strict definition of the medical profession, is not a misnomer but a fact of life for many tennis players.

After studying 84 highly skilled players, a group of 54 men and 30 women that included several of the world's highest-ranking competitors, three Stanford University School of Medicine investigators have reported that elbow symptoms occurred in their subjects "frequently" and "with severity."

In Accord With Earlier Studies

Eleven of the 84 players, or 13 per cent, had suffered "classical" tennis elbow, lateral epicondylitis. This incidence was "striking," but in agreement with earlier studies of international players, said Drs. James D. Priest, Henry H. Jones, and Donald A. Nagel.

Twelve of the players had experienced medical epicondylitis, and seven, cubital tunnel pain.

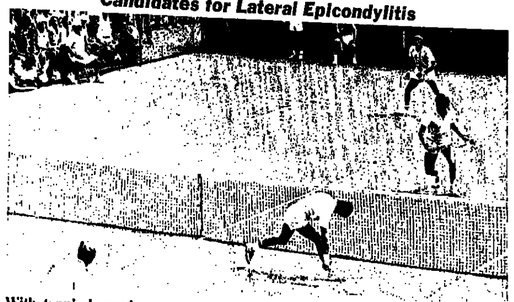
The study was designed to determine what symptoms and changes develop in the elbows of tennis players. It included a medical history and examination for elbow injury, anteroposterior and lateral roentgenograms of both elbows, and photographs of the players.

More than one-third of the subjects had experienced symptoms that the investigators considered "major." The duration ranged from several weeks to 15 years of recurrent pain.

"Nearly all of the symptoms occurred in three regions: the lateral epicondyle, the medial epicondyle, and the groove for the ulnar nerve, also known as the cubital tunnel.

"Almost all x-ray changes were seen on the playing side. More changes were seen in men than in women, and among the men more were medial than lateral. Medial findings were linked to the service motion. Intra-articular fragments appeared to result from fracturing of a hypertrophic spur."

Candidates for Lateral Epicondylitis



With tennis becoming more and more popular, physicians can expect to see more cases of "tennis elbow"—a frequent and severe condition for players.

Blacks Still Face Hate, Bias in Health Field—Dr. Rann

Continued from page 1

ulty meeting that he was prejudiced, a red-neck and could not abide blacks.

"It is ironic that most of this sort of problem is in northern schools—not in the Southland."

Since the American Medical Association now admits black doctors to membership, Dr. Rann said he is asked: "Why N.M.A.?"

"A few years ago," he continued, "a president of the American Medical Association stated in his inaugural address that health is a privilege, not a right. The N.M.A. immediately raised a hue and cry that health is the right of every man, woman and child in America—not a privilege, and soon the A.M.A. altered its stance. Now their philosophy regarding this is the same as ours.

Backed Medicare, Medicaid

"Also a few years ago when talk began on establishing a system of health care delivery, called Medicare, the A.M.A. said, 'No, it smacks too much of socialized medicine!' The N.M.A. said 'Yes.'

"Now, there was some selfish motivation in this stand because for years black doctors had been treating poor people and collections were fragmented. Here, we reasoned, we might get paid for services rendered to the old and poor. Medicare, payment through Social Security, became the law of the land. Then Medicaid was established to provide care for the poor-not-aged and this, too, received support of the N.M.A.

"These items in themselves are justification for the existence of N.M.A. in that this organization has played a big role in leading the way to consideration of the underprivileged masses of our country.

"But there is more. Medicine in America is beset with many problems: The actual number of doctors is insufficient, the distribution of these doctors is not satisfactory, medical care is becoming a political football with the injection of politics into health care by unknowing men who are not able to see the long history of altruistic endeavor by the physicians of our land."

The new president, Dr. Vernal G. Cave of Brooklyn, noted in his inaugural address that health care in the United States lags behind that of some other countries. He cited a life expectancy of 68.3 years for white males in the United States as compared with 61.2 years for black males, and of 75.6 years for white females against 69.3 years for non-white females.

DR. CAVE

Dr. Cave expressed some reservations about the establishment of Professional Standards Review Organizations. "In our society, ill beset by critical racial illness, there is an obvious possibility for PSRO to operate disadvantageously against black physicians and the poor patients, whom they most often serve."

However, he said, "We accept PSRO as the law of the land, and, in spite of the restrictive provisions in the law against meaningful participation by minorities, we must strive at every level—national, state and local—to make our presence felt and fight for the needed changes."

He said the question of physician supply concerns N.M.A. In 1970 practicing physicians in the United States numbered 280,929, of whom 6,106 were black. "This gave us a ratio of black physicians to black population of approximately 1:3,700; whereas the ratio of other physicians to the rest of the population was 1:660. Quite a contrast!"

Dr. Cave said 68,000 graduates of foreign medical schools were in this country at the end of 1972, including only about 2,000 who were inactive.

"Yet, while our Government keeps the doors open wide to these physicians, efforts toward increasing the number of black physicians who are more likely to serve in our undersupplied areas leave much to be desired," he remarked.

Over-60 Group Expected To Double by Year 2000

Medical Tribune World Service

GENEVA—By the end of the century the world population of persons 60 years of age and over will have increased to 585,000,000, according to estimates by a World Health Organization expert committee.

This amounts to doubling the present figure—291,000,000—within three decades, said the committee, which has just released a report on the planning and organization of geriatric services.

The increase, it said, is likely to be more rapid in the developing regions—from an estimated 137,000,000 in 1970 to 354,000,000 in the year 2000.

IMMATERIA MEDICA

By DUDLEY STRAUS

New York City Necrology —1824 and 1825

In 1826 the population of New York City was 166,086; there were 101 churches and 158 members of the county medical society. In that year a James Hardie wrote a book entitled, *The Description of the City of New York: Containing its Population, Institutions, Commerce, Manufactures, Public Buildings, Courts of Justice, Places of Amusement, &c.*

We are deeply indebted to Dodi Schultz, who owns a copy of it, and, inspired by our report of causes of death in old England, has sent us some figures from a section of Hardie's book ("Report of Interments") showing causes of the total of 9,359 deaths in N.Y.C. for the years 1824 and 1825. There were 4,341 deaths in 1824 and 5,018 in 1825, an increase "certainly owing to the excessive heat in the month of July."

Some of the major causes of death were: Consumption 1,579, convulsions 524, stillbirth 494, smallpox 434 (394 in 1824), dropsy in the head 414 (plain dropsy accounted for another 225), old age 354, inflammation of the chest 343, hives or croup (couldn't they tell the difference?) 272, inflammation of the bowels 212, whooping cough 185, intemperance 154, and measles and infantile flux 153 each.

Some more provocative, if minor, causes: teething 107, drinking cold water 80 (77 of these occurred in 1825—could it have been that hot July?), worms 37, abscess 29, asthma and cramp in the stomach 17 each, fracture nine, white swelling 8, gravel 7, carbuncle 4, hysterics 3, caries 1.

In addition, 197 deaths were attributed to unknown causes; 57 persons died of "sudden death"; and four were murdered.

Whether or not the medical examiner, or "Chief Inspector" as he was then known, had an easier time of it than his modern counterpart, is moot.

* * *

Leonardo da Vinci's Mona Lisa seems to have stimulated almost as much interpretation as Shakespeare's Hamlet, and now a retired London physician has gotten into the act, we learn from United Press International.

A Dr. Kenneth D. Keele (specialty unstated) concludes that Mona Lisa "probably portrays a pregnant woman." That smile is one of secret satisfaction, and the "full rounded face and figure and beautifully unjewelled hands reveal to a diagnostic eye the endocrine and electrolyte changes of pregnancy."

Next painting, please.

* * *

"Behind its 19th Century exterior the building, 49 East 68th Street, designated a landmark by the N.Y.C. Landmark Commission, now houses a flexible, automated and multi-media environment."

—*Conflict*, of the Institute for Mediation and Conflict Resolution.

And that's the way it goes these days.